California Victim Compensation and Government Claims Board

Analysis of the Impact of Dental and Medical Expense Rate Reductions on Victims of Crime and Recommendations

August 27, 2004

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Section I: Introduction and Background

Need for Analysis

Two years ago, the Board initiated a series of cost reductions in order to strengthen the Restitution Fund, which had been seriously depleted because record numbers of crime victims applied for compensation. When the Board lowered payment rates, the Board and Program staff agreed that the impact of the dental and medical rate reductions should be monitored and rates should be reassessed as the Restitution Fund stabilized.[1] In early 2004, Program staff conducted an analysis of the effect of dental and medical rate reductions on victims. The analysis showed that the rate reductions, while necessary to make the Restitution Fund solvent again, did have a negative impact on crime victims' ability to access treatment. Over the course of the last year, crime victims have had increased difficulty accessing dental treatment and accessing follow-up medical care because of the Board's low rate of payment. The following document summarizes the results of the staff analysis and details the staff recommendations for changes.

Reasons The Board Reduced Rates

The Board experienced an unprecedented increase in payouts and applications during Fiscal Year (FY) 2001/02. The increase was due to several factors. The Board reduced a backlog of claims and bills, increased rates paid to mental health providers, and processed a record number of applications in the aftermath of the publicity the Board and other victim services received post 9/11.

By July 2002, it was clear that if applications and payouts continued at the existing rate, the Restitution Fund would be unable to support the program. The Board adopted a series of expenditure reductions as part of an effort to preserve the integrity of the Restitution Fund. [2]

- On July 26, 2002 the Board adopted the staff recommendation to pay medical bills according to federal Medicare rates; dental bills according to Medi-Cal's Denti-Cal rates for all services provided on or after September 1, 2002; and to roll back the 2001 rate increase for mental health counseling treatment. Prior to this action the Board had paid medical bills, for the most part, at Workers' Compensation rates, and dental bills had been paid at 100 percent of billed amount.[3]
- On January 10, 2003, the Board adopted service limits for mental health counseling benefits and the staff recommendation to further reduce the rate of payment for medical bills by an additional twenty percent (to the Medicare rate minus 20 percent).

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[1] "Budget Paper for Discussion and Action," California Victim Compensation and Government Claims Board, January 10, 2003. Page 7.

[2] California Government Code §13957.2 "(a) The board may establish maximum rates and service limitations for reimbursement of medical and medical-related services and for mental health and counseling services…"

[3] As used throughout this paper the term "percent of billed amount" refers to the amount of the verified, eligible bills the Board receives. Sometimes providers mistakenly send bills for treatment that are not for the injury related to the crime, and those bills are not eligible to be paid by the Program.

Fiscal Analysis of the Rate Reductions

When the rate reductions were implemented, the Board and Program staff agreed that the impact should be monitored and rates should be reassessed as the Restitution Fund stabilized.[4]

Subsequent to the rate reductions, the Board's fiscal situation worsened because receipt of the annual federal grant was delayed until May 2003. Payments to providers were held between January and May of 2003 due to severe cash flow problems. The Board was only able to make direct payments to victims and cover administrative costs for that period of time.

Had the Board failed to adopt the rate reductions, the Restitution Fund, even with fewer applications received, would probably have been entirely expended in FY 03/04. For the second year in a row, provider payments would probably have been withheld until the receipt of the annual federal grant, which, again, did not arrive until mid-May. The Board stabilized the Restitution Fund by reducing projected expenditures by $12.3 million in the past year (FY 02/03) and by $20.1 million in the current year (FY 03/04). The average cash balance in the Restitution Fund this year was only $30 million. If the Board had not made that reduction of $32.4 million over the last two years, the fund balance would stand at minus $2.4 million.

An analysis of payments made over the last two years shows that:

- Applications received decreased by 1,789 (three percent) from FY 01/02 to FY 02/03 and by 11,285 (18 percent) from FY 02/03 to FY 03/04.
- Bills received increased by six percent from FY 01/02 to FY 02/03 and decreased by 34 percent from FY 02/03 to FY 03/04.
- Total actual claim payments decreased by $5,867,000 (five percent) from FY 01/02 to FY 02/03 and by $50,865,000 (43 percent) from FY 02/03 to FY 03/04.
- Payments for mental health counseling benefits decreased by $7,527,798 (16 percent) from FY 01/02 to FY 02/03 and by $19,980,999 (50 percent) from FY 02/03 to FY 03/04.
- Payments for medical expenses decreased by $ 4,570,666 (11 percent) from FY 01/02 to FY 02/03 and by $13,364,511 (39 percent) from FY 02/03 to FY 03/04.
- Payments for dental expenses decreased by $158,800 (8 percent) from FY 01/02 to FY 02/03 and by $1,023,692 (57 percent) from FY 02/03 to FY 03/04.
- The number of reimbursement dollars applied against verified losses increased by five percent from FY 01/02 to FY 02/03 and by an additional five percent from FY 02/03 and FY 03/04. In other words, the Program has been able to identify more sources of reimbursement for victims, such as private insurance and Medi-Cal.

With the Restitution Fund stabilized and cash flow issues under control, staff directed their efforts toward understanding the cause of the decrease in the application rate. After analysis, no one specific answer emerged that explains the decrease in the application rate, but some of the contributing reasons include:

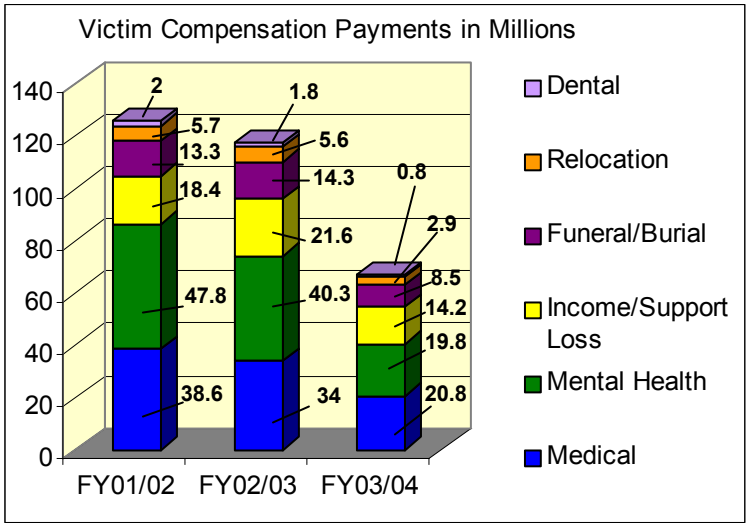
- Reductions in local, state and federal funding for victim services. Most compensation applicants find out about the program through local victim advocates. When less money is available for victim services, fewer advocates are available to do outreach regarding compensation to help victims apply for services.

[4] "Budget Paper for Discussion and Action," California Victim Compensation and Government Claims Board, January 10, 2003. Page 7.

Fiscal Analysis of the Rate Reductions (Continued)

Providers who routinely refer victims to the program stopped taking compensation clients to avoid long delays between the date of service and the date of payment and to avoid having their approved payments held due to cash flow problems.

Table 1. Victim Compensation Payments in Millions FY 01/02 through FY 03/04



History of Past Rate Adjustments

The Program has always sought to balance the need to control costs with the need to ensure access to quality care for victims.

In the early 1990's, the Board began using a contracted bill review service to review and adjust some medical bills, as appropriate, according to various fee schedules adopted by the Board. In 1993, the Program conducted a study to establish a more sensible rate for payment of hospital bills. The study, which included discussions with other government agencies, health care administrators and medical associations, found that, on average, most third party payors reimburse hospital bills at 70-80 percent of the billed charges. Since 75 percent was within the customary range of payment, the Program chose that rate as one that would be accepted by most providers.

Since that time, the Program has customarily chosen 75 percent as reimbursement rate, for all medical, medical related and dental costs that fall outside whatever fee schedule the Board uses. Historically, the default 75 percent reimbursement rate has allowed the Program to ensure that each bill is adjudicated in a standardized fashion, in a timely manner, while generally still meeting the needs of the victim to have access to necessary services.

Prior to July 2002 the Board paid medical payments according to the workers' compensation schedule, generally higher than Medicare. Before adopting the workers' compensation rates in 2002 the Board used a variety of different rates to pay different bills; hospital bills were paid at one rate, physicians' bills at another, and so on.

Impact of Rate Reductions on Victims

Once the Restitution Fund stabilized, it seemed prudent to begin a review of the effect rate reductions had on crime victims around the state and to determine if the decrease in the application rate is an indication that the rate reductions have had a negative impact on crime victims' ability to access services. Staff members were directed to conduct a study of the effect of the rate reductions on crime victims' access to treatment.

Study Methodology

Staff members followed two avenues of inquiry for this study. They analyzed the history of payments for FY 01/02, FY 02/03, and FY 03/04. They also distributed a survey to collect data from the advocates and claims specialists who had direct contact with crime victims affected by the rate reductions.

Advocates in victim witness assistance centers are responsible for helping over three-quarters of crime victims statewide apply to the Program and they assist victims with a wide range of problems. Advocates are the primary source of detailed information about the difficulties victims experience with the Program. Claims specialists from the Joint Powers (JP) Units can provide detailed information about service providers in their communities and how those providers interact with the compensation program.

The survey asked for details about how many victims had been refused service or had difficulty obtaining services and was distributed to advocates in victim witness assistance centers and to claims specialists from the JP units across the state, as well as to claims specialists and other Program staff at the Board. The survey also asked how many providers had indicated they would no longer accept victims who are using compensation benefits to pay for services.

Across the state, 100 advocates and claims specialists from 24 counties responded to the survey. About 60 percent of the crime victims that the Program serves come from one of these 24 counties. When asked to estimate how many victims had been refused service or had difficulty obtaining medical or dental services, respondents identified 2,530 incidents since the rate reductions and about 900 incidents in the year prior to the rate reductions. They identified almost 2,483 problems with providers regarding medical or dental rates since the rate reductions, and only about 500 in the year before the reductions. [5]

[5] See "Attachment C: Dental and Medical Rate Survey" for a summary of the survey results.

Section II: Study Findings

Emerging Themes

The study found that the Board's rate reductions have had a negative impact on crime victims' access to a number of different services. Advocates and claims processors documented more than 1,000 instances where a victim was refused service by a provider because of payment rates or other policies. This is three times more than the number of victims that complained about being refused service by a provider before the expenditure reduction actions became effective in September of 2002.

Several themes emerged from the data collected in the survey.

- Low rates of payment affect access to follow-up care. Comments from the advocates indicated that while hospitals were resigned to accepting the Board's rates for emergency treatment, victims were often unable to find providers who would accept the Program's payment for follow-up care.
- Providers require guarantee of payment. Many providers, such as dentists or cosmetic surgeons, require either payment by the patient at the time service is rendered or preauthorization by a third party provider such as an insurer to guarantee a certain amount of payment. The low rate the Program pays, coupled with the fact that the Program does not pre-authorize medical or dental treatment, has severely curtailed the number of physicians and dentists willing to provide follow-up care to victims.
- Providers reject Program payment as "payment in full." Providers are also accustomed to receiving a co-payment or share of costs from patients who have a third party payor. Many providers object to the statute that requires them to accept the Program's payment as payment in full; especially when they perceive the rate of payment to be extremely low.
- Victims are not fully compensated for out-of-pocket expenses. Advocates and claims specialists reported many instances where victims who paid bills to avoid having them sent to collection, who paid an insurance co-payment, or who simply paid for treatment themselves in order to gain access to services were not fully reimbursed by the Program for their out-of-pocket losses.

The study identified adjustments the Board could make to existing fee schedules that should help to ensure that payments for services in specific service categories are high enough to encourage physicians, dentists, and other medical professionals to treat victims. Findings and staff recommendations for several categories of rates are described below.

Exhibit A:
Dental Rates

Rate Reduction Had Substantial Negative Impact on Victims

Based on comments made on the survey, it appears that even before the rate reduction, when dental expenses were paid at 100 percent, victims experienced problems finding dentists who would accept the Program's payment. Dentists were already reluctant to treat victims because the Program does not preauthorize treatment or guarantee payment, and because the Program is slower to reimburse providers than other third party payors.

Only a very limited number of dentists accept Denti-Cal rates across the State. When the Board reduced the rate of payment to Denti-Cal levels, the action had a devastating effect on victims' access to dental treatment. Although the action directly reduced expenditures by $522,000 dollars a year, total dental payments fell by $1,024,000 or 57 percent. Advocates and claims processors estimated that more than 375 victims were refused dental services during the last year. The rate reduction was so drastic that most dentists refused to accept victim compensation payments, creating huge difficulties for a significant number of victims.

More victims have had to use their own money to pay for needed dental work at the time of service. Of the total payments authorized for dental expenses in the current year, 39 percent went directly to reimburse victims. This is two and a half times (2.5) more than the average number of reimbursements (15 percent) made directly to victims for all other service categories. Many of these claimants ended up with an out-of-pocket loss that was not fully reimbursed. This is also an indication that, to the extent that the victims are unable to pay for at least a portion of the services upfront, they simply cannot access dental services. Between FY 01/02 and FY 03/04 payments for dental expenses decreased 61 percent. This decrease is disproportionately higher than the 51 percent decrease in total payments for providers during the same time period.

In the past few years, before the rates were reduced, the Program paid dental expenses on fewer than 600 claims a year. Historically, dental expenses have made up a small portion of the Program's provider payments (2 percent in FY01/02). However, when an injury is serious enough to warrant dental treatment it usually means broken, lost, or dying teeth; replacement of broken dentures; or some other significant type of treatment. When a victim cannot replace a tooth or a set of dentures, the psychological impact can be devastating. A broken or missing tooth can affect a victim's ability to get or keep a job.

The Board needs to address two issues regarding payment of dental expenses. First, the rate of payment, unacceptable to most dentists, and, second, the fact that even when the Board paid 100 percent of the billed amount, dentists were reluctant to accept compensation patients without a guarantee of payment. In order to begin to restore victims' access to dental care, the Board should adopt the following staff recommendations.

Fiscal Impact

The fiscal impact of the proposed dental rate increase is estimated to be lower during the first year of implementation due to the lag time between the date of service and the date when the

Fiscal Impact (Continued)

bill is paid. The average lag time for most dental bills is about seven-and-a-half months [6]. The annual on-going increase in claims payments associated with the dental rate increase is estimated to be $326,000. With an effective date of July 1, 2004 for the proposed increase and a normal distribution of the payment of bills, staff projects that approximately 60% of the dental bills for dates of service on or after July 1, 2004 will be paid during the current year (FY 04/05). Therefore, the current year impact for this rate increase is estimated to be $196,000.

Pros: The fiscal impact of this change would be moderate enough for the Board to absorb. This change would have a similar fiscal impact to increasing the rate to Denti-Cal plus 25 percent, without the stigma of being based on Denti-Cal rates. A number of additional victims may be able to find providers who would accept this slightly higher rate. This rate of payment is consistent with the amount covered by most third party insurers and equivalent to dental preferred provider organizations (PPOs).

Cons: This rate may not be high enough to make a significant improvement in victims' access to treatment; however, some victims may still not be able to find dentists who will accept this rate as payment in full. If the Board adopts this recommendation, the Program should analyze the impact to make sure that victims have adequate access to treatment, and consider additional strategies if this change does make enough of a difference.

Other Alternatives

The Board could elect to make no change in the rate, however many victims would continue to be denied access to needed dental care.

The Board could elect to pay the Denti-Cal rate plus 25 percent, resulting in an estimated annual ongoing increase of $306,000 in payments. Although the fiscal impact of this option is comparable to the staff recommendation, comments from advocates, dentists and from the Board's bill review service strongly indicate that providers will react negatively to any rate structure that includes the term "Denti-Cal".

The Board could elect to pay 100 percent of the amount billed, resulting in an estimated annual ongoing increase of $685,000 in payments. At this rate payments would be about the same as they were in FY 01/02. Victims' access to dental treatment could potentially be restored to FY 01/02 levels. However, this alternative has a higher fiscal impact than other options and could prove to be an unnecessary increase if improvements result from a combination of increasing the rate to 75 percent of billed and implementing other strategies for improving access, such as some kind of preauthorization of treatment.

Staff Recommendations

1. Pay 75 percent of the amount billed for dental expenses.
2. Establish a pilot project to create a method for preauthorizing payment of dental treatment. (See *"D. Improve Access to Dental and Medical Care"* for details.)

[6] The average time from date of service to date received by the Program is just over five months. The average time from date received by the Program to date paid is just over two months, for a total lag time of seven-and-a-half months.

Staff Recommendations (Continued)

3. Review utilization of dental treatment to ensure that the costs fit within the normal and customary rate of payment and evaluate the change in victims' ability to access dental treatment as a result of the rate increase.

Exhibit B:
Medical Rates for Major Service Groups

Utilization of Medicare

Medicare rates bring uniformity and fairness to the Program's rate structure. When rates of payment are based on Medicare, the Board's bill review service can easily analyze treatment utilization. However, rates for each service need to be considered individually, and the Board's overall rate of payment, while tied to Medicare, needs to be high enough for victims to be able to access services. Many providers do not accept Medicare rates. While emergency care is generally covered, rates that are too low can keep victims from being able to get needed follow-up care.

The Medicare system controls federal payments for medical services to certain populations through the use of fee schedules and payment systems. Medicare was created to provide health insurance to people 65 or older, to some people with disabilities under age 65 and to people with permanent kidney failure requiring dialysis or transplant.

Medicare covers a variety of services and provides a widely accepted system for determining medical payments in various settings. A recent Bureau of State Audits (BSA) report on the California Workers' Compensation Program provides support for the Board's decision to use Medicare as a basis for determining a rate of payment. However, the report cautions that inappropriate fee schedules could adversely affect access to care.[7] The report noted that the 40 states surveyed for a recent study all based their payment structure on some variation of the Medicare Resource Based Relative Value Scale (RBRVS), though states' application of the scale varied widely. Some states pay at the Medicare rate. Some states pay a percentage below or above that rate, and some states vary the percentage depending on the type of treatment, the market conditions, and access to treatment in that state.[7]

Other state compensation programs use a variety of payment strategies. Some discount by a percentage, some use their state's workers' compensation scale, and some make no reductions in medical payments.[8]

Medicare Does Not Cover All Services or Circumstances.

The population that the VCP serves is generally much younger than the usual Medicare population and sometimes requires services that are either not covered by a Medicare fee schedule or for which the Medicare payment is not high enough to ensure access to a reasonable standard of care and service. For instance, because cosmetic surgery is almost always considered an elective surgery, the prices surgeons can charge are based on what consumers are willing to pay, rather than what Medicare or an insurance company will likely pay them. To a crime victim, having a scar removed from their face is not an elective surgery, but rather a critical step in the healing process.

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[7] Bureau of State Audits, "California's Workers' Compensation Program: The Medical Payment System Does Not Adequately Control the Costs to Employers to Treat Injured Workers or Allow for Adequate Monitoring of System Costs and Patient Care", August 2003. Page 87 and Page 94.

[8] See "Attachment D: 2004 Medical Payment Rate Information for Other U.S. Victim Compensation Programs."

Low Rates of Payment Affect Victims' Access to Follow-up Care

The Board's current rate of payment (Medicare less 20 percent) limits victims' access to health care; especially when they seek follow up treatment for their injuries. In many areas of the state patients who use Medicare have to search to find physicians who will accept those rates; finding providers who will accept 20 percent less than Medicare is even more difficult. Victims must find a provider willing to perform the needed treatment, the provider must accept the Board's rates as payment in full, and the provider must also agree to perform the treatment without any guarantee of payment from the Program. Many victims are denied treatment or cannot find providers who will accept these conditions.

Advocates and claims specialists report that many providers consider the Program's current rate of payment for medical expenses inadequate, even insulting. While hospitals have complained about this rate, they are required to assist crime victims with emergency treatment and will usually accept the Program rate for those services. However, when victims seek follow up treatment for their injuries, advocates report that they have encountered numerous difficulties.

The federal government recently changed the way it pays for durable medical equipment (DME), a category that includes drains, catheters, walkers, wheelchairs, prosthetics, and eyeglasses. Acknowledging that the current method using the Resource Based Relative Value Scale (RBRVS) resulted in reduced access for patients to needed equipment, Medicare adopted the slightly higher DME scale. The Board should also use the new scale, except for prosthetics, eyeglasses and hearing aids, which are discussed in following sections.

Fiscal Impact

The fiscal impact of the proposed medical rate increase is estimated to be lower during the first year of implementation due to the lag time between the date of service and the date when the bill is paid. The average lag time for most medical bills is just over nine months [9]. The annual on-going increase in claims payments associated with the medical rate increase is estimated to be $6.2 million. With an effective date of July 1, 2004 for the proposed increase and a normal distribution of the payment of bills, staff projects that approximately 50% of the medical bills for dates of service on or after July 1, 2004 will be paid during the current year (FY 04/05). Therefore, the current year impact for this rate increase is estimated to be $3.1 million.

Pros: Victims will have a much better chance of finding physicians who will provide follow-up treatment and the Restitution Fund is now stable enough to support this additional expenditure.

Cons: The number of providers who will accept this rate may still be limited. The Program should analyze the impact to make sure that victims have adequate access to treatment and consider additional strategies if this change does make enough of a difference.

Other Alternatives

The Board could elect to make no change in the current rate (Medicare less 20 percent), however many victims would continue to be denied access to needed medical care.

The Board could elect to pay medical expenses at the Medicare rate with an estimated increase of $1.6 million in the current year and $3.1 million annually thereafter. This action could increase

[9] The average time from date of service to date received by the Program is almost six-and-a-half months. The average time from date received by the Program to date paid is just under three months, for a total lag time of just over nine months.

Other Alternatives (Continued)

access somewhat, however, many victims would continue to be denied access to needed medical care because many physicians do not accept Medicare rates.

Staff Recommendations

1. Pay medical expenses at the Medicare rate plus 20 percent for services covered by Medicare.
2. Pay at 75 percent of the billed amount for any services that are not covered by Medicare. The fiscal impact of this change is included above.
3. Pay for durable medical equipment (except prosthetics, eyeglasses and hearing aids) using the Medicare Durable Medical Equipment (DME) scale.
4. Establish a pilot project to create a method for preauthorizing payment of medical treatment. (See *"D. Improve Access to Dental and Medical Care"* for details.)

Exhibit C:
Medical Rates for Minor Service Groups

Rate Reduction Had a Severe Impact on Victims Seeking a Few Specific Services

A few minor medical service groups suffered an even greater impact than most as a result of the January 2003 medical rate reductions. Cosmetic surgery, prosthetics, and eyeglasses and hearing aids, and foreign medical bills were included in the Medicare less 20% rate reduction. According to the survey results, our bill review service liaison, and our analysis of the data, victims seeking these medical and medical-related services had their access more severely limited than most due to the rate reductions.

Cosmetic Surgery

When a crime victim seeks cosmetic surgery, it is usually to repair serious damage or to reduce a prominent scar or disfiguration. Although the number of cases where the Board pays for cosmetic surgery is very small each year, only a handful, the impact this treatment has on the victims who need it is enormous. Cosmetic surgery can have a profound effect on the healing process.

Unfortunately, cosmetic surgery was already difficult for victims to obtain before the Board reduced the rate of payment. Cosmetic surgeons are accustomed to being paid in full at the time of service, or to receiving some kind of guarantee of payment from a third party payor, such as an insurance company, prior to providing treatment. They have been extremely reluctant to accept the Medicare less 20 percent rate, and victims seem to have had great difficulty getting help over the last year.

In FY 01/02 the Program made 15 payments for cosmetic surgery for a total of $40,000. In FY 03/04 the Program only made 4 payments for a total of $3,000.

Fiscal Impact

There will probably be a slight additional increase in payments, which is hard to measure, due to victims' increased access to treatment. In other words, victims who are unable to find providers who will treat them now, will be able to get that treatment if rates are raised to this level. Even if the number of victims grew to the FY 01/02 level the increase would still be just under $50,000 based on the billed amount for that year.

The fiscal impact of the proposed cosmetic surgery rate increase is estimated to be lower during the first year of implementation due to the lag time between the date of service and the date when the bill is paid. The average lag time for most cosmetic surgery bills is five months [10]. Based on the FY 01/02 data to account for improved access, the annual on-going claims payment increase associated with the cosmetic surgery rate increase is just under $50,000. With an effective date of July 1, 2004 for the proposed increase and a normal distribution of the payment of bills, staff projects that approximately 70% of the cosmetic surgery bills for dates of service on or after July 1, 2004 will be paid during the current year (FY 04/05). Therefore, the current year impact for this rate increase is estimated to be $35,000. However, the Board should continue to review utilization to ensure that the costs fit within the normal and customary rate of

[10] The average time from date of service to date received by the Program is about three months. The average time from date received by the Program to date paid is just under two months, for a total lag time of five months.

Fiscal Impact (Continued)

payment and to ensure that the effect of the rate increase is to improve victim's access to treatment.

Pros: Victims will be much more likely to be able to access treatment. This option would also reduce the administrative cost of assisting these victims, which is very high given the number of cases in this category each year.

Cons: Though slightly higher than other options, the fiscal impact is still very small.

Providing Prosthetics

Victims who need prosthetics have usually suffered a serious injury, one that impacts their ability to function independently. They cannot resume their daily activities without assistance, and are unable to return to work. Because we are the payor of last resort, these victims have usually exhausted every other resource they can access, Medicare, Medi-Cal, and private insurers, before we are asked to pay for an essential piece of equipment. The Board truly is their last chance, and all too often during the last year, the "Medicare less 20 percent" rate has prevented some of these victims from getting help.

The total amount the Board awards to victims for prosthetics varies, but it is generally low. In FY 03/04 the Program paid $132,000 for prosthetics. Changes in the rates of payment in these categories are likely to increase access to essential services and products for a small group of victims with acute needs at a minimal cost to the Board.

Unfortunately, even Medicare pricing is usually not high enough for most providers of prosthetics to accept the Program's payment as payment in full and victims have been unable to obtain necessary prosthetic equipment at the current rate of Medicare less 20 percent.

Fiscal Impact

The fiscal impact of the proposed prosthetics rate increase is estimated to be lower during the first year of implementation due to the lag time between the date of service and the date when the bill is paid. The average lag time for most prosthetics bills is six months [11]. The annual on-going claims payment increase associated with the prosthetics rate increase is $76,000. With an effective date of July 1, 2004 for the proposed increase and a normal distribution of the payment of bills, staff projects that approximately 65% of the prosthetics bills for dates of service on or after July 1, 2004 will be paid during the current year (FY 04/05). Therefore, the current year impact for this rate increase is estimated to be approximately $50,000. However, the Board should continue to review utilization to ensure that the costs fit within the normal and customary rate of payment and to ensure that the effect of the rate increase is to improve victim's access to treatment.

Pros: Victims with catastrophic injuries would have much greater access to equipment that will make a great difference in their ability to carry out the activities of daily life. This option would also reduce the administrative cost of assisting these victims, which is very high given the number of cases in this category each year.

Cons: None.

[11] The average time from date of service to date received by the Program is about three-and-a-half months. The average time from date received by the Program to date paid is just under three months, for a total lag time of six months.

Providing Eyeglasses and Hearing Aids

Victims who need to replace eyeglasses and hearing aids have suffered a loss that impacts their ability to function independently. They cannot see or hear well without these assistive devices. The total amount the Board awards to victims for eyeglasses and hearing aids is small. It was less than $100,000 in the highest year, even before rates were reduced. Fewer than 158 claimants across the state request payment for eyeglasses and hearing aids each year, but, similar to claimants who need prosthetics, those who do have usually exhausted every other resource they can access, Medicare, Medi-Cal, and private insurers, before we are asked to pay for an essential piece of equipment. However, hearing aids are excluded from all Medicare rate schedules, including DME, so they have been paid at 75 percent of the billed rate over the last year.

Fiscal Impact

The fiscal impact of the proposed eyeglasses and hearing aids rate increase is estimated to be lower during the first year of implementation due to the lag time between the date of service and the date when the bill is paid. The average lag time for most eyeglasses and hearing aids bills is seven months [12]. The annual on-going claims payment increase associated with the eyeglasses and hearing aids rate increase is $30,000. With an effective date of July 1, 2004 for the proposed increase and a normal distribution of the payment of bills, staff projects that approximately 60% of the eyeglasses and hearing aids bills for dates of service on or after July 1, 2004 will be paid during the current year (FY 04/05). Therefore, the current year impact for this rate increase is estimated to be approximately $18,000. However, the Board should continue to review utilization to ensure that the costs fit within the normal and customary rate of payment and to ensure that the effect of the rate increase is to improve victim's access to treatment.

Pros: Victims will be most likely to be able to obtain services if the Board adopts this option. This option would also reduce the administrative cost of assisting these victims, which is very high given the number of cases in this category each year.

Cons: Slightly higher fiscal impact than other options.

Paying Providers Outside the United States

Two other groups who have experienced trouble with the Program's rate of payment are Californians who become victims when they are traveling outside of the United States and visitors from other countries who are victimized in California and have returned to their country of origin for treatment. The Board paid 51 bills for services provided outside the country last year at a total cost of $95,000. However, these bills occupy a disproportionate amount of administrative effort.

In most cases, the foreign provider requires the victim to pay the bill in full before the service is delivered. A provider who does wait for payment might still bill the victim for the remainder of the amount after cashing the Program's check. This is especially common when the victim has returned to their country of origin for treatment.

Additionally, foreign medical providers do not bill on standardized medical forms nor do they code their bills using the standardized codes, which are necessary in order to adjudicate the bill

[12] The average time from date of service to date received by the Program is a little under five months. The average time from date received by the Program to date paid is just over two months, for a total lag time of seven months.

Paying Providers Outside the United States (Continued)

at the Medicare rates. Foreign bills must be translated into English if they are from a non-English speaking country; the billed amounts must be converted into US dollars; the bill must be converted into a Medicare format; the "most applicable" Medicare procedure code must be applied to the translated document; and then the converted and coded bill is reduced at the applicable Medicare rate. The cost of translation, conversion, coding, and adjudication is very expensive, especially in comparison to the cost of reviewing a regular bill. This process is unacceptable in a time when the Board's objective is to find ways to drive the overall cost of processing bills down. While we cannot change the fact that most foreign medical bills must be translated into English, the Board can adopt a rate that reduces the fiscal impact by simplifying the ways bills are reviewed.

Fiscal Impact

This change would have minor fiscal impact with an estimated annual cost of $33,000. However, the Board should continue to review utilization to ensure that the costs fit within the normal and customary rate of payment and to ensure that the effect of the rate increase is to improve victim's access to treatment.

Pros: More expeditious service will be provided to this subset of victims who have historically experienced substantial problems. If the bill is paid at 100 percent of the billed amount, the need for correspondence and/or conversations with victims and providers regarding the bill will be significantly lowered and staff will have a clear direction on how to process the bill thus alleviating numerous discussions with supervisors and managers. Administrative costs will be further reduced because the bills will only need translation and conversion to U.S. dollars by the Board's bill review service contractor rather than the more costly and complex work required to code and adjudicate foreign bills at the Medicare rates.

Cons: None.

Staff Recommendations

Pay the following at 100%:

- Cosmetic surgery,
- Prosthetics,
- Hearing aids and eyeglasses, and
- Foreign providers without regard to the date of service, and accept bills in formats other than the standardized forms required of U.S. providers.

Exhibit D:
Improve Access To Dental And Medical Care For Crime Victims

Advocates and claims specialists who responded to the dental and medical rate survey emphasized that low payment rates are not the only obstacle victims face when they seek help. Attachment A: Dental and Medical Rate Survey Results provides documentation of the numerous difficulties victims have experienced accessing treatment not only within the last year, but also before rates were reduced.

Advocates and claims specialists reported a surprising number of problems related to the fact that the Program had no process to guarantee payment, even before the recent rate reductions. Victims often find they cannot get follow-up care from physicians, surgeons, and dentists who are used to pre-authorizing treatment with third-party payors. Even when the rate the Program paid was higher, providers were reluctant to assist compensation claimants because the Program could not assure them that the procedure would be paid for until after the bill was submitted and the claims specialist determined first, that the treatment was necessary as a direct result of the crime and second, that payments to the claimant had not reached the statutory limit. Dentists and cosmetic surgeons commonly require pre-authorization of treatment, or payment up front from the victim, before they will agree to provide follow-up treatment. If the Program had some process to pre-authorize or guarantee payment in cases where providers required it, victims' access to treatment would be improved.

Failure to pay bills in a timely fashion has also alienated some providers. When the Board was forced to hold payments for four months in the spring of 2003, some providers stopped working with the Program altogether. Recent financial difficulties and a backlog of bills have contributed to a negative impression of the Program on the part of many providers. This negative impression affects the ability of victims to find providers who will treat them. The Program needs to devote resources to sharing information and improving relationships with providers.

Fiscal Impact

The cumulative effect of the various proposals to improve access to care are projected to increase claims payments overall by five percent.

Pros: More eligible crime victims will be able to receive needed services.

Cons: None.

Staff Recommendations for Improving Access to Care

1. Establish a pilot project to create a method for pre-authorizing treatment. Design, implement and evaluate a pilot project for a process to pre-authorize dental and medical treatment. If pre-authorization can be shown to increase victims' access to treatment, it may also help reduce administrative costs by reducing the number and length of contacts that need to be made with victims and potential providers regarding whether or not a bill will be paid. The pilot project should:

    - Establish a procedure to pre-authorize medical or dental treatment. The procedure should include a process to establish whether the treatment was necessary as a direct result of the crime, explain what we can and cannot pay for, and request an estimate of the treatment cost from the provider.

Staff Recommendations for Improving Access to Care (Continued)

- Involve the Board's bill review service to conduct a utilization review that compares the claims in the pilot project to a control group of similar claims to assess if victims' access to services improves.
- Involve victim advocates and providers or provider organizations in the development of the pilot.
- Develop a process that could be integrated into the new claims management system.

2. Design outreach strategies to publicize rate changes adopted by the Board. Collaborate with Victim-Witness Assistance Centers to implement an outreach program to make physicians, dentists and other providers aware of the rate changes and any system improvements. Collaborate to encourage victims who could not access treatment to try again, if possible. Outreach could include activities such as:

    - Publishing updates and Frequently Asked Questions (FAQs) prominently on the Board's website.
    - Designing and distributing printed material written with each type of provider in mind, such as a special flyer for dentists explaining the new rates, giving information on how to help victims, and tips on how to work with the Program.
    - Providing talking points for victim advocates and claims specialists. Encourage them to call affected victims and providers to explain the changes.
    - Writing short items about the rate changes to submit to professional journals and newsletters.

3. Report back to the Board on the effect of any rate changes adopted. Staff should prepare an updated analysis in August 2005 to assess the effect the rate changes have had on victims' utilization of, and access to, needed services.

Exhibit E:
Other Issues Raised By The Study

Victim advocates and claims specialists who responded to the survey also brought up other concerns regarding victims' needs and access to treatment. Some respondents brought up local problems that the Program can assist with on an individual basis. For instance, a few counties reported problems with ambulance services, and one county had significant issues with getting providers to use the correct billing form. However, one issue in particular emerged as a common concern across the state: the Program's current policy regarding reimbursing victims' out-of-pocket expenses.

Reimbursing Out of Pocket Expenses

Although the survey distributed to advocates and specialists did not ask any questions about reimbursement to victims, many of the responses discussed the inequities surrounding the current Board practices for reimbursing out-of-pocket expenses. For the last several years, the Board has not reimbursed victims completely for insurance co-payments or deductibles or for bills that they pay on their own after they have received the initial letter from the Program. When rates were drastically reduced in 2002 and 2003, the problems were exacerbated. The Program would not pay more than the "adjusted rate" of the bill. This has all too often been an amount that was smaller than the victim's co-payment.

In essence, the Program has paid the victim at the reduced rate, rather than reimbursing their out-of-pocket expense. Advocates and claims specialists pointed out that this practice unfairly penalizes victims who have insurance, or who need to pay for treatment up front in order to have access to it. When payments take months to arrive, the providers often send bills to collection, and victims must pay, if they can, in order to protect their credit record. Victims who are fiscally responsible are also penalized because they are reimbursed at the reduced billing rate, rather than for the amount they actually paid.

The Program recently implemented a revised policy that, in addition to reimbursing the victims' co-payments and co-insurance amounts fully, allows payment of the claimants' deductible amounts to be based on the insurance explanation of benefits and share-of-cost amounts on all eligible medical, dental, and mental health bills, without applying a rate reduction.

Fiscal Impact

The projected cost of this change could be as high as $1.3 million annually based on the number of bills received historically that have an identified reimbursement source but no insurance payment. These are likely the bills that will be paid at 100 percent of the billed amount under the revised policy.

Pros: This revised policy is more favorable for insured victims.

Cons: None.

Mental Health Counseling Benefits

This study did not focus on mental health counseling benefits. However, in answering the survey, many advocates and claims specialists mentioned mental health treatment issues. None of the comments were about the rate of payment and only a few of them noted reduced access

Mental Health Counseling Benefits (Continued)

to treatment due to session limits. Most of the comments related to mental health treatment focused on three issues. Providers:

- Complained about the length of time it takes for them to get paid,
- Disliked the excessive paperwork involved in the new system, and
- Expressed reluctance to work with the Program due to the payments that were held in 2003.

Despite the problems cited in response to the survey regarding authorization and payment of mental health treatment, the cost containment measures taken in 2002 and 2003 have effectively reduced the amount the Board pays for theses services and balanced the expenditures in the three primary service categories, medical expenses, mental health treatment and income support. According to a recent study, in 2001, while other states paid an average of 6 percent of their total payments for mental health services, California paid as much as 40 percent of total payments for mental health treatment.[13] Accordingly, the Board identified expenditures for mental health benefits as a cost containment target, hoping to bring expenditures in this area more in line with other states, and with the other primary service categories: medical expenses and income support expenditures. Mental health payments as a percentage of total claim payments were 37 percent during FY 01/02; 34 percent in FY 02/03; and 30 percent for FY 03/04.

The rate of decrease in applications made by direct victims of crime who sought mental health treatment was consistent with the overall decrease in applications in FY 03/04. However, the applications filed on behalf of derivative victims (such as family members or primary caretakers) seeking mental health treatment decreased far more than the rate of decrease overall. The decrease in mental health bills is slightly larger than the decrease in applications for mental health treatment for derivative victims. Providers may be treating fewer derivative victims because of the excessive paperwork required for the limited number for sessions available.

Staff Recommendation

Program staff should continue to evaluate strategies for increasing access to mental health treatment by reducing the paperwork and associated administrative costs involved and expediting the payment process.

[13] *National Evaluation of State Victims of Crime Act Assistance and Compensation Programs: Trends and Strategies for the Future*, Urban Institute Justice Policy Center, March 2003. Pages 17-18.

Section III: Summary of Staff Recommendations

The following staff recommendations, if adopted by the Board, will provide better service and access to California's crime victims.

For all bills with dates of service, on or after July 1, 2004:

1. Pay 75 percent of the amount billed for dental expenses.
2. Pay medical expenses at Medicare plus 20 per cent for services covered by Medicare.
    - Pay at 75 percent of the billed amount for services that are not covered by Medicare.
    - Pay for durable medical equipment at the Medicare DME rate, except for prosthetics, eyeglasses and foreign bills as noted below.
3. Pay the following at 100%:
    - Cosmetic surgery,
    - Prosthetics,
    - Hearing aids and eyeglasses, and
    - Foreign providers without regard to the date of service, and accept bills in formats other than the standardized forms required of U.S. providers.
4. Improve Access
    - Establish a pilot project to create a method for preauthorizing payment of dental and medical treatment.
    - Review treatment utilization to ensure that the costs fit within the normal and customary rate of payment and to ensure that the effect of the rate increase is to improve victim's access to treatment.
    - Design outreach strategies to publicize the Board actions.
    - Report back to the Board on the effect of these actions.
5. Continue to evaluate strategies for increasing access to mental health treatment.

<u>Estimated Fiscal Impact of Staff Recommendations</u>

The total claims payments increase associated with the various proposed rate increases is estimated to be $3,432,000 in the current year and $6,682,000 annually thereafter, based on bills received and paid over the past three fiscal years. The increase in claims payments associated with the revised reimbursement policy is estimated to be $1.3 million annually. The cumulative effect of the various proposals to improve access to care is projected to increase claims payments overall by five percent. Therefore, if the Board adopts the staff recommendations, expenditures for the current year (FY 04/05) are expected to reach a total of approximately $75.5 million.

Long-term projections, including the changes expected from these moderate rate adjustments, show that the Restitution Fund balance will continue to remain stable for the next several years. However, the on-going impact of these adjustments must be evaluated before additional changes are considered. Also, any major changes to the application rate or other external factors will effect the current projections and must be monitored.

Table 2. Estimated Fiscal Impact of Staff Recommendations

	Current Year	Budget Year
FY 03/04 Payments (basis for projection)	67,221,000	
Total Estimated Rate Increase Impact	3,432,000	6,715,000
Total	70,653,000	
Improved Access (estimated at 5% increase)[14]	3,533,000	
Revised Reimbursement Policy	1,300,000	
Total Estimated Expenditures in FY 04/05	75,486,000	83,000,000 (1)

(1) Budget year total estimated expenditures was calculated by adding the difference between the full year and the partial year impact of the rate increases to the current year total estimated expenditures, then adding the assumed five percent growth as follows:

6,715,000 – 3,432,000 = 3,283,000 + 75,486,000 = 78,769,000 + 5% = +/- 83 m.

[14]This is an estimate of the amount that payments would increase due to the improved access to treatment that would follow rate increases.

	Access or Rate of Payment Problems Reported By Victims and Providers		Amount Awarded in the First Six Months of	
Type of Expense	**9/01 to 9/02**	**1/03 to Present**	**FY02/03**	**FY03/04**
Hospitals	252	422	$12,701,853	$5,887,887
Physicians	360	950	$4,002,508	$2,147,801
Dental	198	906	$1,221,330	$393,062
Ambulance	58	236	$953,497	$473,238
Chiropractic	108	204	$527,906	$322,879
X-ray	90	112	$424,296	$221,504
In-home care	51	73	$12,711	$41,628
Physical therapy	67	172	$204,530	$100,854
Med equip	20	51	$137,008	$126,282
Alternative treatment	23	43	$123,002	$67,275
Lab tests	12	25	$79,027	$25,562
Eyeglasses, Hearing	152	248	$34,730	$16,178
Prosthetics	9	15	$20,815	$82,025
Skilled nursing homes	43	30	$6,755	$18,146
Cosmetic surgery	18	65	$906	$1,358
Totals	**1461**	**3552**		

Attachment B: Survey Comments

Advocates and Claims Specialists submitted many comments in the narrative portion of the survey. A number of the comments, representing the chief themes that emerged, are included below.

Dental Treatment

- A dentist declined to replace dentures that were broken . . . his lab fees were more than we could pay.
- Victim who received tooth damage after 9/02: staff received calls from three different dentists inquiring about payment fees. When staff informed them of VOC Denti-Cal rates dentists refused to treat victim. Staff doesn't know whether victim ever received dental treatment.
- At this time, there is one dental office in [our county] that is willing to provide services to the VCP claimants and bill the VCP directly. This provider was actively solicited by this staff and is a provider for the local indigent community. Therefore, they provide a very limited amount of services in an almost substandard environment.
- At a March staff meeting, the victim advocates informed us that many dentists on the referral list were not accepting new victims for treatment. The dentists thought the Denti-Cal rates were too low. Moreover, the advocates are having a difficult time finding new dentists who would do so.
- Denti-Cal has denied request to replace dentures. Dentist gave an estimate of $2,535. BRS [the Board's bill review service] reduces to $600. Dentist advised he can't afford to do work. Victim is without dentures.
- This unit is still seeking a local dentist who will treat victims with no other source of reimbursement.
- Dental providers in our area refuse to provide service without payment in full prior to rendering services.
- Four victims asked me for a dental provider list, since they were turned down more than three times. My only answer to them so far has been to find a Denti-Cal dentist. I have had two victims got to a regular dentist, pay in full, and again be [partially] reimbursed by us. They preferred losing out-of-pocket than to go to a Denti-Cal dentist. I would not go to a Denti-Cal dentist.
- Every dental provider I have dealt with is **not** willing to accept VCP reimbursement.
- I have a case right now where the victim's two front teeth were knocked out due to the crime. He testified at the trial despite his fears, and the district attorney asked for my help in finding a provider to get the victim's teeth fixed. The dental offices that I have haggled with tend to be very strict in their demand for pre-authorization or cash at the time of service, and when they learn our rates, it is rare that they will return my calls.
- We had a case of drunk driving where a seventeen-year-old victim had all of her teeth knocked out due to the crash. The rate of payment made it extremely difficult for the family to access services. The dentist took the case only because of political pressure and state that no future clients of our program will be seen by his office due to the low rate of pay.

- The most recent example has been a dentist who did not accept the check we had sent him. He stated he wouldn't even break even with the check we had sent him. He states that the reason Denti-Cal dentists survive was that they have to do a certain number of patients a day, and it was sloppy work.
- Most of the time the claimant has to pay for the services before any work is done; therefore, the claimant is not reimbursed at 100 percent rate. Most dental providers are demanding full payments before any work is done and since the Board cannot pre-authorize dental work, the claimant has to pay for the services.
- If the victim needs to see a dentist, the provider will not provide treatment unless they get authorization or a guarantee from the program that they're going to receive payment in full the victim then has to come up with the full amount, pay for the services, and them they'll get reimbursed whatever amount BRS allows.
- I am aware of several victims that are unable to receive dental services due to the low rate of payment. No provider will accept our low rates.
- "We had a dental provider who told us that they would send the check back to the compensation program because the allowed rate of the program is so low. The provider then held the victim responsible for the expenses."
- It seems that the most difficult services for victims to access because of our pay rates are dentists. Most dental offices what the payment up front, and those that are willing to wait for payment from the Program often complain about the pay rate they receive. They then tell the victims that they will not perform any other services until payment in full is received, when your pay rate does not come close to the full amount.
- On more than one occasion, I've had victims refused to be seen due to the Board's rate of payment for dental services. There are few if no dental offices in our area that are willing to accept what the Board pays for dental expenses… On a recent case the victim was referred to a dentist for treatment. The lowest allowable amount, discounted, was $2,000 [was charged] by the dentist. BRS came back with reduced rate of $1,450, which the dentist would not accept so the client was turned away for service.

<u>Medical Treatment</u>

- Many providers of medical treatment are "shocked" at the VCP's rate of payment. I have been advised by these providers that they will not treat VCP clients/victims. I have been called by VCP victims that they cannot find a doctor to treat them because of our low rate of payment. These victims are very concerned that they are unable to obtain the necessary treatment for their crime injuries.
- Physicians refused services to victims due to lowered rates and amount of time it takes to get the payment. Some physicians refused payments and sent the checks back.
- Victim was assaulted and struck in the left eye with a beer bottle. Vcitim had emergency surgery the same day for a ruptured globe, cornea laceration and eyelid laceration. In the following months the victim tried to have further surgery to repair his eyesight, however, he had no insurance. When he told providers he had applied for compenstaion, they would tell him that they knew they would probably not get paid.
- Many providers who do not accept Medicare because of the rates will no longer accept VOC for the same reason.

- Victim's leg was broken due to crime. After he lost his medical insurance, he continued to have difficulty with his leg injury. He wanted to return to his regular orthopedist (the one who did the original surgery), but the doctor did not accept our rates. It is unknown if the victim received any continued care.
- [Because I work within the Korean community,] many victims prefer to visit private Korean doctor's offices. However some of them will not take payment [unless] we can call the doctor's office to give them an 'ok,' but we cannot do so for obvious reasons and the victims must go to another treatment center.
- Victims who needed follow-up surgery and/or who needed continuous medical care after the emergency room [had difficulty accessing services because of the Board's rate of payment.]
- Providers who call prior to providing services are generally off-put by the low rate of reimbursement and often refuse to provide the service to the claimant. They often note that they do not provide service to patients with Medicare or Medi-Cal eligibility only for the same reason.
- Some physicians refused payments and send the checks back.
- It is our impression that many medical providers do not even bother billing victim compensation any more because they have learned that id does not do them any good. We used to reduce bills by 25 percent. Now the reduction tends to be in the 80-95 percent range.

<u>Cosmetic Surgery</u>

- We have a victim who needs reconstructive surgery for his face, which was badly disfigured. There is not one plastic surgeon in [three nearby counties] that will work with the program. They state that the rates are too low.
- The county has no specialty doctors, orthopedics, plastic surgery, etc. that will work with the program. Begging the providers is useless.
- I had one specific case for cosmetic surgery, where the victim worked at a medical center and felt more comfortable with the doctors she worked with. When she went in for the first treatment, and the doctor received our check at a very low rate, the doctor told this victim that he would not continue services unless she was willing to pay in full, and up front. The victim was distraught in this case because she had a disfiguration on her face, and the treatment could not be completed.

<u>Eyeglasses and Hearing Aids</u>

- Victim received injury to her eye causing double vision. Was given a prescription for glasses with prisms to correct her double vision. Staff called numerous offices to fill her eyeglass prescription. No office would accept 20 percent below Medicare rates. Staff notes that many times this condition of double vision is temporary; but, if left uncorrected by prescription, can result in permanent condition.

- Because of the excessive MDX reduction on hearing aids, we have also lost the only audiologist providing service to VCP claimants – this provider has been an invaluable ally in the community previously.

Lack of Timeliness of Payment

- After about two billing statement cycles, the bills get transferred to a Bill Collection Agency. The Bill Collection Agency then proceeds with letters stating that they will file a suit unless certain payments are made. The victims cannot often make these payments and contact us, the advocates. We, in turn, call the collection agency or the hospital and ask for an extension. Sometimes, the victims are lucky and receive an extension and other times, they do not.
- Providers refuse or have ceased working with the program due to bill reduction policy or because providers do not understand rates and procedures for payment; also due to time it takes to get reimbursed.
- I've had some providers very upset with the program, stating that they do not get paid on time. Therefore, providers contemplate canceling future sessions or have claimant pay for sessions and submit for reimbursement.
- Therapist in [rural area] refuses to deal with VOC anymore due to slow payment methods. She is the only therapist in [rural area].
- [Board] is very slow to process payments. They are behind about 2 to 3 months per claim. The providers call regularly to find out what is holding up payment. I'd like to ask why it takes so long. Most of the bills end up in collections before they get paid.

Reimbursement and Insurance Issues

- Claimants who can afford to pays up front do so in order to receive treatment from a provider of their own choosing. While they are upset/angry when their entire out-of-pocket loss cannot be reimbursed, they don't change providers.
- It is very difficult for victims to understand why their co-pays are not being paid for them. They are financially responsible for the co-pays and the VCP was set up to reimburse victims' out of pocket expenses. Victims feel that they are being 're-victimized' by the very same program that boasts we will help you financially recover from your victimization. The VCP is penalizing victims for having health insurance.
- I have worked with dozens of victims who have experienced problems addressing compensation assistance when health insurance co-payments were applied. For example, one victim of an assault with a deadly weapon needed surgery, multiple doctor appointments, and dozens of physical therapy sessions to repair damage done to his knee. The co-payments were only $10 to $20 per session, but the cumulative amounts were significant. The Board's denial of his out-of-pocket medical expenses posed a severe financial hardship on this victim and his children. This is often the chief complaint from victims about the compensation program, that they feel penalized when they use insurance benefits after a crime.
- The Board needs to make it very clear that if the claimant pay for medical or MH expenses, they will NOT be compensated at 100 percent if the payment is higher than

our rate, and it is unrealistic to expect the victims to not make payments when they are under pressure by the provider and credit agencies and when it takes the Board a long time to address these bills.

- Victims with insurance are being penalized by the program. Insurance pays their portion, BRS reduces the bill, which is always lower than the insurance rate of reimbursement, so the victim ends up paying their co-pays and more. This has been an issue for years, and we have yet to get this resolved. There should be no out-of-pocket loss for victims."
- We've had providers return the check and demand full payment from the claimant.
- Victims with insurance are having to swallow their co-pays because the rate of reimbursement is lower than what would cover their co-pay ... I am embarrassed to over them a program that in essence tells them they are being punished for having insurance.
- We had one victim's family which had to terminate in-home aide services due to the Board's low rate of payment to the service provider. It created a heavy financial burden for the family of a disabled victim. Other problems that victims have experienced is the low BRS amounts which do not cover the "patient responsibility" after insurance consideration – many victims have voiced their difficulties in having to make these payments "out-of-pocket."
- The biggest problem I am having on a weekly basis is the problems with the [domestic violence] relocation program. It is simply not working for my victims in this area. They cannot get emergency funds and the claims are taking anywhere from a minimum of two to three months to process.

<u>Mental Health Treatment Issues</u>

- Several mental health providers complained about the length of time to pay bills, especially after the session limits came into effect in 2003. We had a large backlog and at least three different providers complained to me that they would have to stop taking any more Victims of Crime claimants due to the delay, but I don't recall them complaining about the rate of pay . . . The main problem for quite a while was the backlog in responding to ATP reviews, but that seems to be improving.
- There have been a couple victims experiencing difficulty with regard to payment to M/H providers. They were refusing to see victims as a result of not receiving payment from VOC and advised victims to pay before they could be seen for appointment. Victim did not have the personal funds but victim was in crisis and in need of services.
- A client was looking for a therapist and said that some of the providers she spoke to would not see her based on the VOC funding because they were not feeling secure with the payments. She asked me if I could refer her to someone else that didn't have these issues. I referred her to the local non-profit DV agency.
- We have had about 10 mental health providers over the last 2 years ask us to remove their names from the resource list we give to victims. All of them stated the low rate of reimbursement and increased paperwork led to their decision to not see victims in their practice.
- Though I have had very few complaints about the rate there have been at least five victims who have paid the therapist up front at a higher rate, and then took what reimbursement we could offer them. This is because these victims had worked with the

particular therapist, had established a relationship, and knew the therapist had been useful in the past for them.

- Claimants want to see a psychiatrist for meds. We have no psychiatrists on our provider list.
- Have lost a few mental health providers due to rate reduction and when provider payments were being held. Additionally, providers have complained about treatment plan forms . . . Also, psychiatrists refuse to see VCP clients who have no other reimbursement sources due to how little we pay.
- Mental health providers have expressed concern on whether they would get paid on time. I have not had complaints about the rate of payment.
- Main problems were victims trying to find therapists, many of whom stopped taking the program due to slow payment and misunderstandings about the program "running out of money.
- We are now having some therapists who will no longer work with the program due to the limits on therapy and the length of time it takes to get paid.

<u>Funeral Burial Expenses</u>

- Funeral/burial applicants have had problems getting reimbursement due to vehicle insurance not getting verified prior to decision.
- Regarding deaths related to vehicle incidents (DUI). The potential of reimbursement from auto insurance and/or from a civil action slows down the process and payment of benefits from VOCP. Providers become impatient and potentially will not cooperate when future incidents occur.
- The lowering of funeral and burial rates by VOCP has made it very difficult for surviving family members of the victim(s) to be able to obtain those services incurring minimum expenses. The average cost for a funeral and burial in our area is between $7,000 and $10,000.
- The soft cap of $5,000 has really put pressure on claimants who pay for these services. Only once have I had an f/b bill that was less than the soft cap, and this bill was about $4,900. The rest of my f/b claims are well over one to two thousand dollars above the soft cap. In addition, the majority of f/b bills do not have other reimbursement sources. Most of these claimants are left still paying thousands of dollars out-of-pocket. This is quite a loss.
- There was one FB expense for a child killed at a local park where the body had to be transported to another county and his parents had the body prepared and buried in their religion's cemetery. The total of mortuary and cemetery costs were over the soft cap of $5,000. It was sent for Board's review and subsequently denied.

Attachment C: 2004 Medical Payment Rate Information for Other U.S. Victim Compensation Programs

Information provided by Dan Eddy, Executive Director, National Association of Crime Victim Compensation Boards.

Alabama:	30 percent of billed amount
Alaska:	temporary reduction to 85 percent in FY 2004, not expected in FY 2005
Arizona:	policy of negotiating for 50 percent reduction
Arkansas:	75 percent
California:	Medicare fee schedule minus 20 percent
Colorado:	some districts at 80 percent
Connecticut:	no general reduction
Delaware:	contracts with some facilities to pay 80 percent
D.C.:	no general reduction
Florida:	33 percent in recent fiscal year
Georgia:	no general reduction
Hawaii:	no general reduction
Idaho:	no general reduction
Illinois:	no general reduction
Indiana:	no general reduction
Iowa:	no general reduction
Kansas:	80 percent
Kentucky:	no general reduction
Louisiana:	70 percent
Maine:	75 percent
Maryland:	no general reduction
Massachusetts:	fee schedule from rate-setting commission
Michigan:	no general reduction
Minnesota:	80 percent
Mississippi:	no general reduction
Missouri:	no general reduction
Montana:	no general reduction
Nebraska:	no general reduction
Nevada:	fee schedule
New Hampshire:	75 percent, but only if hospital evaluates and denies free care
New Jersey:	fee schedule
New Mexico:	no general reduction
New York:	no general reduction
North Carolina:	no general reduction
North Dakota:	80 percent
Ohio:	no general reduction
Oklahoma:	80 percent
Oregon:	workers compensation fee schedule
Pennsylvania:	70 percent
Puerto Rico:	unknown
Rhode Island:	workers compensation fee schedule

South Carolina:	no general reduction
South Dakota:	no general reduction
Tennessee:	no general reduction
Texas:	state medical fee schedule
Utah:	85 percent through memo of agreement with hospitals
Vermont:	no general reduction
Virgin Islands:	unknown
Virginia:	policy of negotiating for 25 percent reduction
Washington:	workers compensation fee schedule
West Virginia:	no general reduction
Wisconsin:	2/3 of bill
Wyoming:	no general reduction